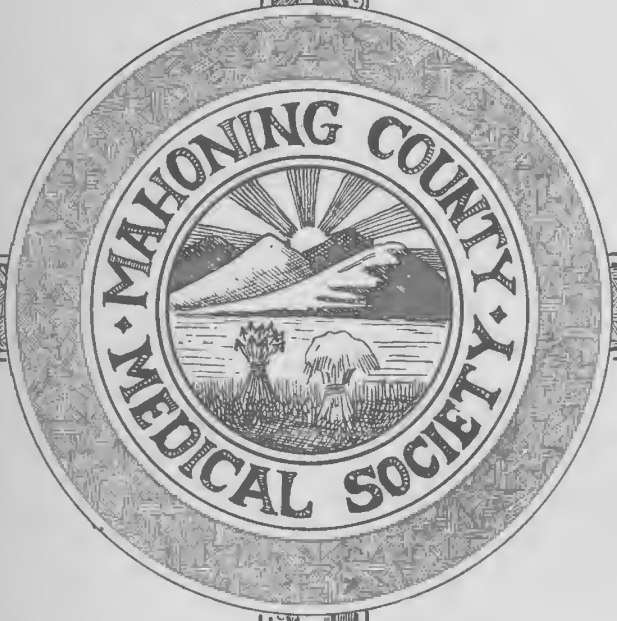


"Well, if I ever love another country, damn ME!"

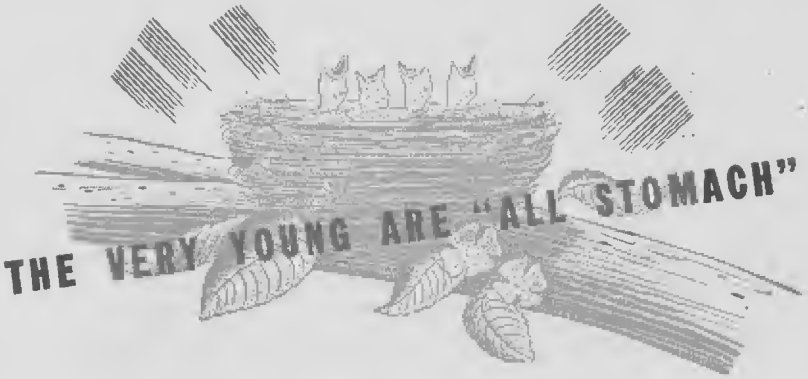
Thompson—"Presidents I've Known."

BULLETIN

of the

Mahoning County Medical Society

Vol. XII No. 6
June 1942



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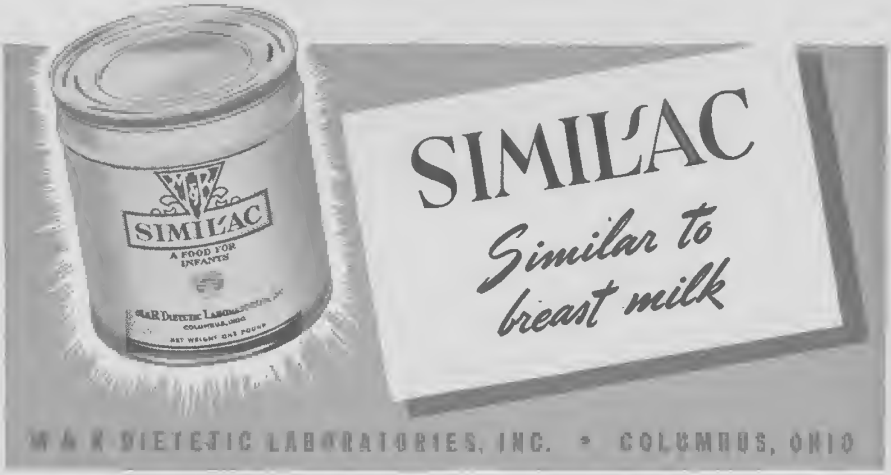

THE MAHONING COUNTY MEDICAL SOCIETY

OFFICERS AND COUNCIL

BULLETIN COMMITTEE

CLAUDE B. NORRIS, M. D., *Editor*

ASSOCIATE EDITORS

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ADVERTISERS' LIST

Patronize them—they make the "Bulletin" possible

★ **PATRONIZE OUR ADVERTISERS AND MENTION THE BULLETIN** ★

PRESIDENT'S PAGE

• • •

Sufficient time has now elapsed to clarify facts and dispel false rumors regarding the position of the physician in the war. When the writer saw his fellow colleague burst from a chair in the staff room when interrogated about the Army sending all the physicians to Texas, it exemplifies the point. A "gag" of course, but it proves the nervousness of physicians regarding their position is more pathetic than amusing.

Youngstown has been selected as one of the 12 centers for visitation of the Ohio Medical Officers Recruiting Board on June 18th. The writer hopes that it is understood this board is only interviewing those physicians who present themselves voluntarily. Also, this board will interview physicians who come to them for advice regarding a Commission with no obligation to accept such a Commission at this time.

Copies of the latest War Bulletin of the Ohio Committee on Procurement and Assignment for Physicians and Committee on Medical Preparedness will be placed on the Bulletin Boards of the hospitals. All physicians should read this Bulletin as a "rumor dispeller."

A word to the "stay at home's"—perhaps it would be better to put it in the form of an order—Better still, let's say, more pointedly, it is your PATRIOTIC DUTY to serve on call or otherwise on either Dr. Joe Hall's or Dr. O. J. Walker's Committees. "Too Busy" is no excuse. When even one physician offers such an excuse, it throws the program out of line and is entirely unexcusable. A few may do the work of many, in so far as the Medical Society activities are concerned, but, when it comes to the war effort it's all out one hundred per cent.

WALTER KING STEWART, M. D.
President.

BULLETIN of the Mahoning County Medical Society

JUNE 1942

Editorial---

Half-Way

This month marks the end of the first half of 1942.

Our profession, although never forgetting our joint responsibility with other citizens for winning the war, has not lost sight of the essential of medical improvement.

Already more than 20 of our active practitioners and over 15 interns have responded to the call of the Army and Navy, including the Marine and Air Services. Report comes daily of the early leaving of many more.

How many Mahoning County Physicians are within the eligible ages? A check shows our total membership to be 242, excluding non-resident members. Of these 117 are 45 years of age and under, 84 are between 46 and 60; and 41 are 61 and over. This means that considerations of age will leave more than 100 of our membership still subject to possible call. Of course, physical unfitness and other reasons will cut the number down to some extent.

Our members will not shirk nor waver in their response. We are Americans, ready to die for our Country as some have already done.

Those who remain at home will not forget our comrades who go away. We shall buy bonds and stamps and pay taxes, and not grouse about it. We shall do our part in the Community effort for Community and War Relief. We shall continue to serve our draft boards in examining draftees for the Army. We shall cooperate to the fullest extent in Civilian Defense.

We can do no less; may God help us if we would deny our Country more if we find it within our power to do more!

1942

Let those tallow spines who would have us lie down short of Victory squirm. Men of character seek no quarrels, but the bully who attempts too many insults will find that his hand has been called. And no matter whether the fight is equal or not—the bully learns that he has acquired a real chore before the contest ends. We'd fight this war if we knew we'd get licked—but we know we won't.

C. B. N.

Dr. Kasper

Last month Dr. Joseph A. Kasper gave us a sane and well balanced discussion of the various acute infections. All of his address was well documented with experimental data, organized to establish definite points of importance, or pointing in a challenging way to more investigative work.

The practical aspects of such a discussion were readily apprehended by his large and attentive audience.

It is always pleasing to a speaker when his listeners discuss points that he has tried to make. That feeling remains and is increased if further elaboration is requested, or if added testimonial is adduced to fortify the speakers conclusions. It is helpful, too, if the evidence set out fails to convince some one, who, because of interest, largely stimulated by the speaker, gives a divergent point of view on some phase of the subject under consideration. This can but react upon all as a means to thought and more careful observation.

Dr. Kasper succeeded in a gratifying way in his efforts to teach, and, more important perhaps, he made us think. He thus gave us a fruitful, scientific evening.

SOME ASPECTS OF ARTERIOSCLEROSIS

By Roy W. Scott, M. D.

(Delivered before the Society, March 17, 1942)

Long ago it was said: "A man is as old as his arteries." This truth is more apparent today than ever before. Clinical experience and that refined form of it that we call "statistics" point to a steadily mounting incidence of vascular decay, which today is killing more people than any other disease. No wide search is necessary to justify a discussion of human arteriosclerosis, since it is clearly the major medical problem facing the present day physician, and there is every reason to believe that it will be even a more serious problem for the doctor of tomorrow.

In America in 1900, one out of every 20 people was 60 years of age or better; in 1930 one out of 12, and by 1960, statisticians estimate that one out of every 6 individuals will be 60 years of age or better. Primarily responsible for the increasing life span is the ancient and honorable guild to which you and I belong, therefore, we of all others should be concerned with the medical and perhaps also with the social implications of our handiwork. How much of our effort comes as a mixed blessing, how near have we come to the creation of a social Frankenstein? Already a few far sighted economists and sociologists have called attention to the mounting financial burden of the care of the aged and have warned that unless some solution is found it may prove too heavy for our existing social structure. In this connection we are reminded that Medical Science has created a biologic hot house environment in which an increasing number of the physical, mental and moral unfits may mature to propogate their inferiority. For this we spend billions, while on the other hand, more billions are poured into the making of instruments of destruction to butcher the flower of the stock. May we not ponder the ultimate results of our present day methods as applied to the human race?

If the solution of the problem of arteriosclerosis appears difficult to the sociologist, it seems even more obscure to the physician. We consult statistics and find that vascular disease is, at the present time, the chief barrier to longevity and the major factor determining individual expectancy. How often we see individuals in the prime of life struck down by vessel disease. It is exacting a formidable toll in our own ranks in the form of coronary thrombosis, hypertensive heart disease, cerebral hemorrhage and thrombosis. In the face of such facts we strive to explain them, only to find that our ignorance of this most common affection far overshadows our knowledge. Hypotheses there are in abundance, but these frequently express opposite views concerning the cause and nature of human arteriosclerosis.

Obscure as the etiology of human arteriosclerosis is, clinical experience indicates the important role that heredity plays in determining the wearing quality of our arteries.

An inherited pre-disposition to early vascular disease and a familial tendency to essential hypertension in many cases, are well established. As more people are now surviving to the later decades of life than ever before, and as more weaklings are reaching maturity to propogate their inferior stock, one sees little hope either of preventing the disease or of reducing its mounting incidence in the future.

Aware of the limitations in our knowledge we can speak with no assurance regarding either the prevention or the cure of arteriosclerosis. However, from clinical and post mortem observations we do have im-

portant information which helps us to appreciate the variety of clinical pictures exhibited by patients dealing with vascular disease.

At the post mortem table we find that arteriosclerosis is most capricious in its distribution, appearing in the greater circulation from the sinus of Valsalva to the remote ramifications of the vascular tree, and for some reasons not known at present, the arteries of the lesser circulation, in most cases, are singularly spared. The process may be generalized in some instances and sharply localized in others. The functional significance of arteriosclerosis varies greatly: often there is no paralellism between the extent of the process and the associated functional disturbances.

For instance, we see extensive changes in the larger arteries that offer no barrier to longevity, and on the other hand, the process may be confined to a few millimeters of the coronary artery and cause sudden death in the prime of life. The affection, particularly in young people, may involve the renal vessels and, advancing rapidly, lead to marked hypertension and death in uremia. It is apparent, therefore, that we must be prepared to see a great variety of clinical pictures associated more or less intimately with vascular disease. Thus we see examples of coronary arteriosclerosis with the clinical picture of angina pectoris, or coronary thrombosis, in patients who have never had an elevated blood pressure. Also cerebral arteriosclerosis leading to the clinical picture of senile dementia or hemiplegia occurs in patients who may or may not have had hypertension.

Finally there is the older patient with chronic hypertension who dies in uremia and the younger patient with so-called malignant hypertension who succumbs rapidly from renal insufficiency.

This brings us to the consideration of a problem which has baffled physicians for decades, namely the relation between arteriosclerosis, hypertension and kidney disease. Thanks to the work of Goldblatt, one aspect of the problem is elucidated, namely the relation of hypertension to renal disease. He has shown that constriction of the renal artery of one kidney in both the dog and the monkey causes an elevation in the systolic and diastolic pressures which lasts for weeks or months, whereas, narrowing of both renal arteries at once or after an interval results in persistent hypertension, which has continued in some animals for ten years. The elevated blood pressure following the constriction of one renal artery promptly returns to normal on either removal of the ischemic kidney or release of the clamp on the artery—a crucial experiment illustrating the role of the kidney in raising blood pressure. Chronic hypertension is observed in animals that show no evidence of renal excretory insufficiency. This is the experimental counterpart of so-called benign essential hypertension in man. Also the picture of malignant hypertension with uremia, including widespread arteriolar necrosis, can be produced almost at will by further narrowing of the renal arteries. In other words, a dog with benign hypertension lasting for several years may be thrown into the malignant phase with uremic death in a few days; or the acute malignant phase can be produced in the beginning by severe constriction of both main renal arteries. In these experiments is seen the same baffling picture which has puzzled clinicians for the past hundred years, namely, the occurrence of hypertension not only with but without renal excretory insufficiency; yet the elevation of blood pressure in both instances is clearly of renal origin.

Thus the argument that essential hypertension cannot originate from the kidney because there is often no

accompanying impairment of renal function is no longer valid.

The failure to find renal arteriolar disease in a few persons with essential hypertension is often cited as evidence that elevated blood pressure has nothing to do with the kidney, but the possibility of severe sclerosis of the main renal arteries sufficient to cause renal ischemia has not been excluded. Until recently such cases have been overlooked and classified as instances of essential hypertension without renal arteriolar disease.

The experimental hypertension in animals without demonstrable evidence of renal excretory insufficiency is the experimental analogue of benign hypertension commonly seen in patients. Similarly, when the renal arteries of these animals are still further constricted uremia develops with extensive retinal lesions, and post mortem examination shows arteriolar necrosis like that observed in malignant hypertension in man.

For the production of arteriolar necrotic lesions in the animal two factors are essential: (1) Hypertension and (2) progressive renal insufficiency—the same combination that always occurs in the malignant phase of essential hypertension in man.

Whether the hypertension associated with primary renal disease also results from renal ischemia is a problem for the future to disclose, but it is likely that such disease of the kidney may so alter its circulatory dynamics that the functional effects on systemic blood pressure may be the same as in primary vascular disease.

All the experiments bearing on the pathogenesis of the hypertension induced by renal ischemia, indicate that it is not of reflex nervous but of humoral origin. Some chemical substance circulating in the blood and formed as a result of renal ischemia constricts the peripheral arterioles and thus elevates the blood pressure. By the same mechanism, human essential hypertension is best explained. In support of this view is the recent work of Printzmetal and Wilson and of Pickering who have demonstrated that essential hypertension in man is not of vasomotor origin.

Although Goldblatt's work throws no light on the nature of human arteriosclerosis, it goes far in clearing up the problem of hypertension which has baffled clinicians for decades. It is now possible to understand why patients exhibiting sclerotic changes in the vascular system may or may not have arterial hypertension. If the renal vessles are sufficiently involved in the process, hypertension appears; if they are spared, the patient may show no significant elevation in blood pressure, in spite of arteriosclerosis elsewhere in the body. Furthermore, it now appears that the clinical course pursued in hypertension is determined primarily by the progress of the vascular disease in the kidney. This in the majority of cases is sufficient to cause chronic hypertention, but not rapid enough to impair renal excretory function. Thus most hypertensive patients die of heart failure or of a cerebral accident before uremia develops. However, the renal vascular changes may progress to a point when the clinical picture of so-called malignant hypertension with uremia appears. In other words, the progress and extent of the vascular disease in the kidneys determine whether essential hypertension runs a benign or a malignant course.

As a pathologist, Jean Oliver, in discussing the so-called normal senescence of man, says: "As a part of the senescent process there develops a generalized sclerosis of the smaller arteries. The vascular changes within the various tissues and organs may be severe but there is no evidence that compels the conclusion that these

lesions produce an elevation of blood pressure. If the arterial change within the kidney is sufficient to produce renal ischemia, however, hypertension follows. Depending on the degree of renal arterial involvement, the hypertension may be benign and senility end with mild circulatory difficulties and a beneficient bronchopneumonia; or more grave, cardiac failure or cerebral accident, depending on the local condition of the blood vessels, may terminate in more dramatic fashion life's last episode. By such concept it is not so much vascular senescence, common to all organs and tissues, that determines the ultimate outcome, but a disturbance within the kidney is the final and actuating mechanism of senile circulatory failure and accident. A man's arteries may be old, but only if his kidneys are spared does his senescence approach the biological ideal of a gradual and peaceful decline."

Looking back over the past century we see Bright's original postulate regarding the renal origin of hypertension, at first accepted, then questioned and finally in recent years, largely rejected. Now as a result of Goldblatt's epoch-making work, the pendulum swings back, the kidney assumes the major role in the etiology of essential hypertension and Bright stands vindicated, although it has taken more than a hundred years to do it.

Accepting the view that human essential hypertension is a symptom of renal vascular disease, the question naturally arises: What causes the sclerotic changes in the kidney vessels? Since these changes differ in no fundamental way from those seen in other arteries, our problem is, in reality, that of human arteriosclerosis. Here we stand on the threshold, three centuries after Harvey, facing in almost complete ignorance the greatest unsolved problem in medicine today. As Albutt once said "We are groping in the dark for something in the dark."

Time does not permit a detailed discussion of the many aspects of vascular disease but to mention some of its more common clinical manifestations is to emphasize the importance of the subject to the practitioner of medicine. Although as we have seen, patients dealing with the problems of vascular disease may or may not have hypertension, yet, it is well known that an elevated blood pressure, with or without symptoms, is often an early and persistent finding in many cases. Therefore in the time remaining I will comment briefly on the management of the patient whose vascular disease is associated with hypertension.

Examination Of the Patient With Essential Hypertension

An elevated blood pressure should be regarded as a symptom serving to direct our attention to a careful examination of the patient's entire vascular system with particular attention paid to any subjective evidence pointing to an impaired circulation in three vascular beds: heart, brain and kidneys.

Experience teaches that the symptoms, clinical course and life expectancy of the majority of hypertensive patients are determined by (1) the capacity of the heart to meet the demands thrown upon it, (2) by the wearing qualities of the cerebral arteries and (3) by the functional capacity of the kidneys. Evidence, therefore, which may throw any light on the state of the vessels in these areas or on the rate at which the sclerotic process is advancing, may be valuable in prognosis and in the sound management of the patient. The discovery of an elevated blood pressure only marks the beginning of an adequate survey of the problem.

The Heart In Essential Hypertension

It is obvious that the heart bears

the brunt of the burden in hypertension, and it is therefore not surprising that more hypertensive patients die of cardiac failure than from any other cause. The left ventricle hypertrophies to meet the increasing demands and may continue competent for many years, but sooner or later its reserve becomes exhausted and we have such early symptoms of an overworked heart as breathlessness on exertion and nocturnal attacks of cardiac asthma. At this stage the heart may be demonstrably enlarged, the left ventricle may be dilated and one may hear an impure first sound or the apical systolic murmur of relative mitral insufficiency. Other valuable signs of a failing left ventricle are a gallop rhythm and a pulsus alternans, the latter often detected by the use of the blood pressure cuff. Over the range of a few millimeters under the systolic pressure only half the beats are heard with the stethoscope. Since well over fifty per cent of hypertensive patients have significant coronary artery sclerosis, we may encounter angina pectoris or coronary thrombosis before any evidence of myocardial failure appears. Aware, therefore, of the load carried by the heart in hypertension, the practioner is not surprised that it should finally fail. More remarkable indeed is it that the heart is able to carry on as long as it does in many cases.

Cerebral Manifestations Of Essential Hypertension

The vast majority of hypertensive patients have at post mortem, well marked cerebral arteriosclerosis, and depending on the site and extent of the process, we may have a variety of clinical pictures. For example, one observes transient attacks of aphasia, paresis or paralysis and other focal brain symptoms which may continue for a few minutes or hours and clear up suddenly and completely. Widespread cerebral arteriosclerosis may lead to atrophy of the brain and the picture of so-called senile dementia. Cerebral thrombosis or hemorrhage may occur and produce the well known picture of apoplexy and paralysis. It is not unlikely that many of the nervous symptoms observed in some hypertensive patients, for example, headache, vertigo, insomnia, etc., are due to sclerotic changes in the cerebral vessels. The limitations imposed by cerebral vascular disease often spares the heart so that one sees patients recover from an apoplectic stroke and survive for several years, in spite of a well marked hypertension.

Kidneys In Essential Hypertension

We have pointed out that the smaller renal vessels are involved at necropsy in the vast majority of patients who exhibit essential hypertension during life and we have subscribed to the thesis that hypertension in such cases is a symptom of the renal vascular disease. We recall also that for many decades after Bright, the chief barrier to the view that hypertension was of renal origin, was the fact that the vast majority of hypertensive patients never develop renal excretory insufficiency but succumb to heart failure or a cerebral accident. Only about ten per cent of the cases develop renal insufficiency and die in uremia and the majority of these are young people. It is in this type of case that we most often encounter the so-called malignant type of hypertension in which for reasons not understood, the renal vascular disease runs a rapid course, the kidney function is soon impaired and death in uremia ensues. The most reliable clinical evidence that a case of hypertension has progressed to the malignant state with death from uremia imminent, is afforded by the ophthalmoscopic examination of the eyegrounds. Here one sees edema of the disc as a characteristic feature of the neuro-retinitis, as well as old and recent hemorrhages. Such changes in the eyegrounds may ante-date by

(Continued on Page 179)

Honor Roll

In Military Service

From Private Practice

Raymond S. Cafaro	J. S. Goldcamp	Asher Randell
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Martin E. Conti	S. J. Klatman	J. A. Rogers
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Margaret Davis	Dorothy Oswald	Madaline Vrancich
Dorothy Dibble	M. Schnurrenberger	Ellen Andre
Mary Hovanec	Mary Taddei	Mary Louise Smith
Agnes Keane	Freda Theil	Stella Sylak

We shall do our very best to carry each month the names of all medical professional people who are in any branch of Military Service. In order that we may miss nobody, will those who enter the service, and other members of the Society, please see that I am notified promptly? Furthermore, we at home would be delighted to have a word from you for the Bulletin. Won't you tell us about yourselves and as much as you can about your service?

CLAUDE B. NORRIS, Editor Phone 37418

JUNE

●

LOREN W. SHAFFER, M. D.

Director, Social Hygiene Division
Detroit Department of Health

Professor, Dermatology and Syphilology
Wayne Medical College, Detroit

Subject

"Modern Management of Early Syphilis"

Dr. Shaffer will deal specifically with the Massive Treatment of Syphilis. This subject has been much before us during the past few years. Dr. Shaffer is one of the nation's outstanding syphilologists. We, therefore, are most fortunate this month both in our speaker and in his subject. The speaker will present a number of illustrative sound films.

Tuesday Evening, June 16th, 8:30 P. M.

YOUNGSTOWN CLUB

Some Aspects of Arteriosclerosis

(Continued from Page 175)

several weeks or indeed months the appearance of significant renal excretory insufficiency and uremia.

Changes observed in the fundus oculi are common and often of great diagnostic import in all cases of hypertension. Narrowed retinal arteries from vaso-constriction may appear early in essential hypertension and sclerosis of the retinal vessels affords valuable evidence supporting diagnosis in questionable cases. Many cases of benign hypertension may have some impairment in renal function as indicated by an inability to concentrate urine although they may never progress to the stage of renal insufficiency. It is well to mention here that the appearance of edema in essential hypertension is almost always cardiac and not renal in origin since, as we have seen, heart failure is common, renal failure is rare.

Treatment of Essential Hypertension

We may take it as a self-evident proposition, that the sound management of a sick patient depends on the physician's knowledge of the disease process responsible for the clinical picture he observes. The more accurate information we have regarding such questions as the etiology of the disease, its natural course, its amenability to any form of treatment at present available, the more rational will be the treatment the patient receives. Sound therapeutics have ever followed in the wake of advancing knowledge of disease. Our changing conceptions have often caused wide swings of the therapeutic pendulum. For example, it was not so long ago that the physician felt impelled to administer an anti-pyretic to lower the body temperature in many cases; now we are actually producing fever artificially, secure in the knowledge that the patient dealing with many infections fares better with a natural elevation of temperature than with one lowered by drugs. May not the same general principle apply to the treatment of essential hypertension? May not the elevation in systemic blood pressure in essential hypertension be a natural response to guarantee a more nearly normal circulation in such organs as the heart, brain and kidneys? Until such questions can be answered in the negative, they merit serious consideration in any discussion of the therapeutic management of essential hypertension.

Too often our therapeutic efforts are focused entirely on ways and means of lowering the blood pressure, whereas, our zeal in this direction should, at least be tempered by the evidence indicating that essential hypertension is but a symptom of renal vascular disease which is, in turn, one manifestation of human arteriosclerosis. Therefore, the therapeutics of essential hypertension is fundamentally that of arteriosclerosis.

Since the role of renal ischemia in causing hypertension is now firmly established, every hypertensive patient should be carefully studied, so that instances of unilateral renal disease may be apprehended and cured by operation. Several such cases have been reported in the past two years. The elevated blood pressure promptly returns to normal upon operative removal of the diseased kidney.

Management of the Asymptomatic Patient

It is well known that many hypertensive patients carry on in a normal way for years until they learn of their elevated blood pressure.

How often one sees such individuals running from one physician to another to have their blood pressure taken, and to what avail. Unnecessary restrictions of one kind or another are imposed which do no good and only remind the patient that he must be in a bad way. He may envision a stroke of apoplexy and his

emotional reaction to the situation may result in a considerably higher blood pressure. It is well to emphasize, therefore, that many cases of essential hypertension not only do not need any treatment but are much better off without it. Generally the less said about the blood pressure in such people the better. Since individuals with essential hypertension deal with a chronic affection, they are easy prey and are often victimized. By following some course of treatment a cure may be subtly implied if not promised. For such patients sound medical counsel is of vital importance and in managing them, nothing quite takes the place of the homely quality we call common sense. To institute a sensible regime of living to the end that the patient exercise moderation in all things, is our first consideration. An effort should be made to dispel any phobias engendered by previous mismanagement. For example, hypertensive patients are told not to eat meat, particularly in the form of red meat, and many develop a veritable phobia about meat in any form. Rigid protein restriction does no good and may actually cause anemia and general body weakness which often disappears as the patient resumes a normal protein intake. The same may be said of all special dietaries that have been suggested for the management of essential hypertension. Rigid salt restriction, for example, has been advocated, but no sound evidence is at hand to show that hypertensive patients do any better on a salt poor diet than on one containing sufficient sodium chloride to make food palatable. To enlist the active co-operation of the patient is not always easy, but none the less important. He should be told, in words he can understand, something of the nature of his disease and here one should avoid reference to possible future complications such as heart failure or cerebral accident which may be years in the future. The elevation in blood pressure may be explained as a natural result of the changes in the arteries with advancing years and, possessing no specific remedy to put back the hands of Time, we should not promise the patient a cure, but rather impress him with his own responsibility in the case of his problem. His willingness and ability to adjust his life to whatever sensible restriction may seem indicated, may be of vital importance as the years go by. There is little to lose and much to be gained by reassuring the patient, even though we believe that his future is not cheerful. Such questions pertaining to his outlook should be discussed with some responsible member of the family.

Treatment of Hypertensive Patients With Symptoms

Here we deal with a large group of patients with essential hypertension who sooner or later consult us for symptoms other than those arising from a failing heart, a cerebral accident or renal insufficiency. Headache is perhaps the most frequent symptom encountered although patients also frequently complain of tinnitus and dizziness. In the management of such cases we should be guided by the same general principles outlined above. Faulty habits should be corrected, excesses in all directions avoided and adequate physical and mental rest obtained by the use of sedatives if necessary. Because of the well known effects of suggestion in many cases, informal psycho-therapy may be tried. The diligent administration of a placebo is often effective. The symptomatic improvement following such measures, as well as the spontaneous fluctuation in blood pressure seen in many instances, forces one to be very critical in evaluating the alleged specific effect of the numerous remedies that have been suggested for the treatment of essential hypertension. Among these we may mention dietary restriction of meat and salt, high colonic irrigation, the extraction of teeth and tonsils, ab-

stinence from alcohol, tobacco, tea and coffee, the injection of a variety of endocrines, the excision of part or nearly all of the autonomic nervous system, etc.

Appreciating that the elevated blood pressure is a symptom of a chronic and (so far as we know) incurable disease, and aware of its mounting incidence, we are not surprised that a wide variety of drugs has been used or that none of them has won universal acclaim. Too often conclusions are reached from uncontrolled clinical observations and certain remedies are praised for a short time only to be found valueless upon more careful investigation. Such has been the story of the vast majority of remedies advocated for the treatment of essential hypertension.

Of the drugs employed at the present time for the treatment of essential hypertension, the sedatives are most often effective in controlling nervous symptoms. The relaxation induced by a good night's sleep may also cause a considerable fall in the blood pressure. The bromides, barbituric acid derivatives, such as phenobarbital, and chloral hydrate, singly or in combination, are effective; and in the extremely nervous patient one may use codeine or even on rare occasions, morphine.

The nitrites which lower blood pressure by peripheral vasodilatation, have been widely used in patients with essential hypertension. Their action, however, is fleeting and except in individuals with angina pectoris their therapeutic value is limited. Symptomatic relief does not always follow a lowering of the blood pressure; indeed some patients feel worse as their pressure is lowered by nitrites. On the other hand, nitrites may relieve headaches in some hypertensive patients who are subject to periodic elevations of blood pressure above the level they ordinarily maintain.

The lowering of the blood pressure with amelioration of symptoms has been reported from the use of the sulphocyanates in about one-third of the cases treated. To avoid the appearance of toxic symptoms such as nausea, vomiting, delirium, exfoliating dermatitis, Barker has suggested a method to control the blood level of the drug. By maintaining this between 6 and 12 milligrams per hundred cc. of serum, the more serious complications are prevented. However, the risk of toxic symptoms precludes the routine use of the sulphocyanates, but when controlled by regular estimation of the blood concentration, they may be given to a patient without renal impairment, whose symptoms have proved refractory to all other forms of treatment.

The blood pressure lowered by sulphocyanates returns to its former level with discontinuance of the drug and whether or not the patient receives any permanent benefit from its use is a matter difficult to decide.

Of the scores of other drugs, including various organ extracts that have been used to lower blood pressure, little need be said here. The administration of estrogenic substances such as ovarian extract often gives marked symptomatic relief to women in the menopause, but it is difficult to determine whether the fall in blood pressure observed in cases results from the medication or from the relief of such menopausal symptoms as hot flushes, emotional instability, insomnia and various other nervous symptoms.

Venous section is a valuable therapeutic measure in cases of heart failure with cardiac asthma but it is of little value in lowering an elevated blood pressure. In the first place, the actual drop in pressure resulting from the removal of 500 cc. of blood

is slight in most instances and secondly, the pressure rapidly returns to normal after the venous section.

The latest suggestion to appear on the therapeutic horizon for the treatment of essential hypertension comes from the surgeons who propose a variety of operative procedures designed to denervate (1) the splanchnic vessels (2) the kidneys and (3) the adrenals, with or without adrenalectomy. It seems a far cry to hope that the section of nerves anywhere in the body will remove the cause or influence the course of renal vascular disease; therefore, an operative cure for essential hypertension appears quite out of the question. On the other hand, an operation which actually increases the blood supply to the kidneys might possibly lower the systemic blood pressure and serve as a palliative measure in the management of cases of essential hypertension. In spite of the favorable results as reported by some surgeons, we have as yet no sound evidence to show that their benefited patients live any longer or that the operation in any way retards the progress of their vascular disease. True, some patients who have submitted to one of the various operative procedures tell us they felt better afterwards, but how often we see the blood pressure rising to the preoperative level and the patient end with heart failure, a cerebral accident or in uremia. Until it is proved that an operation actually increases the blood supply to the kidney, resulting in improvement of the renal function in those cases in which it is impaired, the physician is on sound ground in viewing the whole question of the operative treatment of essential hypertension with skepticism. The writer has observed no patient in whom an operation for essential hypertension has even approached a cure; some have been temporarily relieved of symptoms, others not benefited at all.

Summarizing the management of the patient with essential hypertension we may reiterate, that so far as we know, he deals with the problem of arteriosclerosis and specifically with that of renal arteriosclerosis. Ignorant of the cause and of the factors which influence the progress of the disease, we have no cure and must, therefore, content ourselves to treat symptoms as they appear. We must appreciate that the patient has a chronic and progressive affection and that he will most likely succumb to his vascular disease. The knowledge of these well established facts supplies the foundation upon which all rational treatment must rest.

Dr. Hathhorn Busy

"Dr. Hathhorn surely keeps after us," said one member of the Mahoning County Nutrition Council.

"Select the right foods, prepare them properly, eat them sensibly,"—this seems to be the guide to health through good Nutrition. School lunch improvement is on the program, the phase of the work now in effective operation in the schools of Mahoning County and in the Campbell and Lowellville Schools. The thing is that the cost per meal is astonishingly small.

With Dr. Hathhorn's leadership, good results are assured.

OUR SOCIETY FIFTY YEARS AGO

Youngstown, Ohio, May 10th, 1882

Mahoning County Medical Association met in regular session in the office of R. D. Gibson, Vice President McCurdy in the chair. The following program was observed:

Reading of minutes of previous meeting.

Censors report being called for was read by the Secretary.
The report read as follows:

"We report favorably to the applications of Drs. W. T. Miller, C. L. Floor and M. D. McCandless and ask more time on the application of J. J. Louis." Signed by Buechner and Whelan.

The report was received and the Society elected Drs. W. T. Miller, C. L. Floor and M. D. McCandless as members of the association, followed by instruction from the chair to comply with the regulations of the Society's By Laws Art. 2 which requires members to subscribe to the Constitution and By-Laws and pay in to the Society Treasury the sum of One Dollar. Upon motion of Dr. Wilson, Drs. Hottel and Littlefield were invited to sit as corresponding members for the evening.

On motion the discussion of Bronchitis was deferred one month on account of the absence of Dr. A. M. Clark who was to have opened it. Report of cases being called Dr. McCurdy reported a case of compound comminuted fracture of the arm involving the elbow joint followed by exfoliation of all pieces some being quite large, followed by complete ankylosis of the joint. The patient at the same time had leg broken which united promptly. Dr. Whelan had no report ready consequently was given an extension of time, Reports of Committees being called. Dr. Wilson, chairman of the Committee on Ways and Means of giving impetus to society, read lengthy report but action was deferred until next meeting. Committee on "Revision of Fee Bill" was ready to report, but the advisability of adopting a Society Fee Bill being a point which the society was unsettled, a motion to defer action upon it for a month was carried. New Business being called, Dr. Buechner was elected delegate to the American Medical Association, which meets at St. Paul, Minn., the first week of June, 1882, and Dr. Gibson elected delegate to the Ohio State Medical Association which meets in Columbus, O., the 15, 16, and 17, of June, 1882. Upon motion Dr. Wilson read a post mortem report. The subject being of special interest on account of several congenital deformities together with height and weight, they being respectively 4 ft. 11½ in. and less than 100 lb. On motion the program will be observed at the June session which was observed at this session with the exception of Dr. McCurdy on report of cases, Dr. Wilson being substituted. Adjournment.

W. S. Matthews, President
R. D. Gibson, Secretary.

1892 Roster

President, J. McCurdy; Vice President, R. D. Gibson; Secretary, Ray E. Whelan; Treasurer, R. H. Barnes; Librarian, C. C. Booth.

Censors, M. T. Clark, J. E. Woodridge, A. C. Wilson.

R. H. Barnes, J. G. Bennett, C. C. Booth, D. Campbell, O. Canfield, Ida Clark, M. S. Clark, J. E. Cone, J. S. Cunningham, J. A. Dickson, R. D. Gibson, J. C. Gorsuch, H. H. Hawn, J. B. Kotheimer, Brier Hill, O.; R. L. Montgomery, J. McCurdy, J. F. Preston, A. W. Shiller, Greenford, O.; W. C. Stafford, J. J. Thomas, W. A. Werner, Austintown, O.; W. J. Whelan, Ray E. Whelan, W. H. Whitslar, Cleveland, O.; A. C. Wilson, J. E. Woodridge, J. O. Yost, Haselton, O.

COMPLETING THE PICTURE

The following article appeared in a recent bulletin of the Merchants Credit Bureau of Youngstown. Articles such as this don't "just happen." This is a step in the general direction of an educational program to the commercial credit grantor in an attempt to force recognition of the *doctor's dollar*. This article was written at the request of the Merchants Credit Bureau following a talk given by Mr. J. L. Price, Manager of the Medical-Dental Bureau before a regular meeting of the Merchants Credit Bureau attended by the credit executives of the commercial field. This cooperation between these bureaus is conducive to better paying habits of your patients and a more wholesome respect for good professional credit.

"The Medical-Dental Bureau of Youngstown is recognized by members of both professions as a practical demonstration of cooperative endeavor in centralized control and management of the common business problems relating to the practice of medicine and dentistry. While its membership is restricted to members of the medical and dental professions, much value can be derived for the commercial credit grantor by securing information on the paying habits of his customer or potential customer from this organization. Investigation may disclose a person so heavily obligated that to extend further credit would jeopardize the account from the beginning. Pressure brought to bear at a later date means that the debtor will seek the easy way out through the bankruptcy courts. The Bureau emphasizes the constructive character of its work with its members and also the educational factor in striving to create a new sense of public responsibility towards doctor bills. Hence we are selfishly interested in seeing that you men and women in the commercial field have a complete credit picture upon which you may intelligently predicate a basis for the future extension of credit.

"The existence of the Bureau's credit exchange has a stimulating effect upon the patients' paying habits. However, by supplementing this clearing house of professional delinquencies with that of your own Merchants Credit it is hoped that this effect upon the public will become increasingly greater. *Prevention of delinquent professional accounts* marks the Medical-Dental Bureau as being basically different than the ordinary agency which must depend on revenue from collections entirely. Bureau members are assessed monthly dues which has enabled this organization to become a dignified, specialized and representative service in the broad field of the business side of medical and dental practice.

"Our financing service is regarded by many in the profession as the most helpful arrangement yet to be inaugerated. It may be said to represent a step in the right direction of a better adjustment of medical and dental care for the lower income brackets of society. The cost for this pre-payment plan or pre-arranged plan of payment is only 6% to the patient. This service is rapidly expanding as doctor and patient alike realize the value and benefits of such a plan. For the patient it means a convenient way to pay unexpected costs of illness for which they are truly grateful; for the doctor it means no bad debt losses, no patients asking for a reduction, no bookkeeping worries.

"Complete the credit applicant's picture by securing the experiences of the professions through your bureau. The doctor is a citizen of the community and one whom we could not do without. HIS DOLLAR DESERVES CONSIDERATION."

A Children's Question

(To Our Fathers on Earth)

By Margaret S. Marshall

We are the Polish children—
We are the English—French—
Russian and German children—
Childhood speaks from the trench.

We stare at the raiding fleets
Dropping their poisoned death;
Our mothers fall in the streets,
Gasping through shell-torn breath.

We flee through the storm and dark
Enemy submarines.
Bursting shells soon find their mark—
Tell *us* what it all means.

We are the yellow babies,
Living on fear—and rice—
Deep-bitten by war's rabies,
Less important than mice.

We are your flesh and your bone,
Black—brown—yellow—and white
When the earth is yours—alone—
What matters who was right?

When at last the conquered world
Lies at your feet . . . and when
Childhood's flag is ever furled,
Will it matter? . . . much . . . then?

JUNE SONG

If you waken, do not call me,
At five-thirty, sonny dear,
Or you'll have the maddest mamma
In the Juneday of the year!

If you *must* wake up so early,
Never call me, do you hear?
Turn your cheek upon the pillow,
Haply pound your other ear!

MEDICAL-DENTAL BUREAU BUSINESS MEETING

Since distribution of the Bureau Bulletin it has been found necessary to change the date of the Annual Meeting from the 11th to the 25th because of other conflicting dates.

The Medical-Dental Bureau will hold its annual dinner and election of directors on Thursday, June 25, at 7:00 P. M., at the Tod Hotel. The dinner will be complimentary to the members and a large turnout is expected.

Under the capable management of Mr. J. L. Price the Bureau has had a very successful year. Every department has functioned efficiently. A detailed report of the Bureau activities will be mailed to every member before the meeting. The telephone service has operated 24 hours of every day. The collection department has brought in over one hundred thousand dollars for the doctors. The Budget Plan department has financed hundreds of medical and dental accounts, rendering a service to the public and keeping patients out of the hands of higher priced loan companies.

The experience thus far with the operation of the Budget Plan has been so successful that the board of directors will have a surprise announcement to make concerning it at the annual meeting.

During the year the Bureau has conducted an educational program consisting of monthly forums at which have appeared noted economists, editors, college president, military officers, and two presidents of the Ohio State Medical Bureau. A wide variety of problems which affect the two professions were discussed at these meetings and on several occasions medical motion pictures were shown.

As a member of the Chamber of Commerce and the National Credit Association, the Bureau has taken part in civic affairs and has conducted a program of civic education on the importance of professional accounts in their relationship to general credit. The secretarial department has donated many hours of work to the Civilian Defense programs and the Program on Nutrition. A public speaking class for doctors was sponsored and an enthusiastic class was graduated in April under the leadership of Mr. Ray Fellers. Early in the year the entrance fees paid on joining the Bureau were returned to every member.

Doctors of Mahoning County can well be proud of their Bureau which is owned and operated by themselves, and which has long since taken its place as one of the best in the nation.

SINCE LAST MONTH

Dr. and Mrs. Lewis K. Reed announce the birth of a daughter, Ruth Alice, born on May 12 at North Unit, Youngstown Hospital.

Dr. and Mrs. A. Earl Brant and their daughter, Mary Elizabeth were in Providence, R. I., attending the commencement at Brown University where their son, Earl Evans Brant, was graduated. Mr. Brant is entering the freshman class at The Jefferson Medical College of Philadelphia.

Dr. and Mrs. Frazer F. Monroe are now residing at their new home in West Blvd., Cranberry Run.

Miss Edith Frances Regan, assistant professor of education at Mercyhurst College for Women and Dr. Henry Sisek, a surgeon, a member of Youngstown Hospital staff, were married in Cleveland Saturday, May 9, at Blessed Sacrament Church. After the breakfast and reception at Cleveland Hotel they left for a brief motor trip south and then went by plane to San Francisco where Dr. Sisek is stationed with the U. S. Army.

Dr. and Mrs. James L. Fisher spent a few days at Stephens College, Columbia, Mo., where their daughter, Margaret Ethel, was graduating. Miss Fisher accompanied her parents home.

Dr. Walter J. Tims left May 14th to join the Air Corps at Patterson Field, Dayton.

Dr. and Mrs. J. L. Scarnecchia have taken possession of their new home on Tod Lane.

Dr. R. E. Whelan is still convalescing in St. Elizabeth's Hospital and is getting along very nicely.

Dr. I. C. Smith presented a paper on "War Medicine" and Dr. F. W. McNamara on "War Surgery" at the May meeting of the Staff of St. Elizabeth's Hospital. Dr. Saul Tamarkin presented a number of films and spoke on "Foreign Body Localization."

LT. SAM KLATMAN, M. C., SEES THE WORLD

You will enjoy this from our Sam. Now, all you old friends, men and women, in Uncle Sam's service: Won't you follow this fine example and drop us a few words about yourselves?

Dr. C. B. Norris, Editor,
Lincoln Ave.,
Youngstown, Ohio.

Dear Dr. Norris:

As one of the associate editors of the Mahoning County Bulletin, I am exercising my perogative of writing this letter for possible publication in the Bulletin. I thought perhaps it might be interesting to relate some of the experiences I have had since my entrance into the Army. As you perhaps already know my orders were to report from home to the port of embarkation at San Francisco. During my trip across the country, I saw some of the sights which before were only moving picture scenes to me and needless to say I was entranced by them. Some of the ones which stand out in my memory were the Rocky Mountains, the Great Salt flats and Great Salt Lake of Utah, the snow capped Sierra Nevada Mountains. In California there were the San Francisco-Oakland and the Golden Gate Bridges, the Golden Gate itself, the San Francisco Bay and Alcatraz Island.

My stay in San Francisco was short lived for no sooner had I reported in and before I had time to get any equipment, I was immediately assigned to the Army Transport Service and put in a cab and placed on a boat. My trip on the boat proved to be quite interesting. This particular boat was being converted into an Army transport and I had

the opportunity to supervise the construction of a 36 bed hospital complete with operating room and pharmacy together with the requisitioning of all the equipment and linen, etc., that goes with the operation of a hospital. My experience along these lines being limited merely to a recollection of what I had seen around the hospital at home, it created quite a problem. However, on my arrival at Seattle, the commanding Colonel who made the inspection approved everything as was with only a few minor suggestions and changes. There was one fly in the ointment, however, and that was that I kept no records of the work I had done. I knew nothing about records and was quite happy at the time in the thought that I was going to get out of the paper work one hears about so much in the army. I was soon corrected on the count and was sent to the Station Hospital at Fort Lawton on detached Service for the purpose of learning something about the army system of keeping records.

I believe that I will enjoy the Transport Service because I am in complete charge of my own hospital with full responsibility for all persons traveling regardless of rank. It is very similar to private practice and one can anticipate seeing all of the things which might appear in civil practice for a similar number of persons. The hospital has complete equipment for the performance of any type of surgery or for the treatment of any usual ailment.

My stay at Fort Lawton will be very short and then I will be on the move again. If nothing else the Army certainly is giving me the opportunity to see the world.

Lt. Samuel Klatman, MC.
Fort Lawton, Wash.

ALONG THE BATTLE FRONT

Think Realistically About Dependents

(New York State Journal of Medicine)

The impending necessity for many physicians to enter the armed services raises the question of the maintenance of dependents. Numbers of medical men do not view the pay and allowances of army service in the lower officer grades as adequate to maintain themselves and to provide support for those dependent upon them. This, of course, is a matter which varies in each individual case, and must be considered apart from other factors which might becloud the issue.

Most of the medical men under and over forty years of age have lived in this country in an economy which has flagrantly boasted of a high standard of living. It has been drummed into them that this was "The American Way of Life." Particularly during the last twelve years, the ingenuity of the leaders of political and economic thought has been exercised in heroic efforts to raise this standard. It is therefore not at all surprising that at the present time when many physicians are revolving in their minds the problems related to the maintenance of their dependents that they think in the terms in which they have been educated to think by every means at hand—the press, the radio, the forum, the pump priming, the expanded public works program, and the "social gains."

It has not yet penetrated to the consciousness of many people that the total war in which we presently find ourselves engaged requires a radical reversal in our mode of economic thinking. Our economy, because of this total war, is or should be dedicated to the production of an abrupt fall in the standard of living. This fact has been played down, bypassed, hinted at obliquely. As a result, it is our belief that many medical men in considering the question

of the maintenance of their dependents, should they be commissioned for service, have thought in terms of the now non-existant standard of civilian living. *Dependents will not live from now on at the old level;* they will do without many things; they will make many old things do or go without. Furthermore, they will do this cheerfully; they are Americans.

We urge upon the readers of these pages some realistic thinking along these lines. *There is a job to do. It must be done quickly.* We feel that it will be done quickly, that medical men will do it, as they have always done it when their thinking on the subject of their prior obligations has become clarified.

They do not need to be told that already the United States Navy has lost about 5,700 men, including 2,400 killed, 2,300 missing, and 1,000 wounded—said to be more than the total naval casualties hitherto in the history of the Nation—to have impressed upon them *the serious need for services such as only they can render.* No physician worth the name takes his obligations lightly—either national, professional, or personal.

Regards to the Axis

(Pittsburgh Medical Bulletin)

We've just returned from an inspection of war factories in California, or maybe it was Connecticut or Pennsylvania or Illinois; or, for that matter, any other of the forty-eight states or the Canadian provinces. This plant used to make knitting needles or watches or children's tin jumping jacks. Now it's making machine guns or anti-aircraft shells or tank treads or bomber motors. We're sorry we can't be too specific but actually it doesn't matter—the story of intense productivity is everywhere we've been throughout the nation. When you see it, you realize how we're racing.

Imagine the biggest building you can—the one with the biggest floor space. Imagine every square foot of it covered with a machine, a machine that's turning and spinning and polishing gleaming steel. Imagine the noise and the clatter, the banging of the forges, the whirr of the grinding stones, the steady rat-tat-tat of the drills easing their way through hard metal. Cover this with the fumes and smoke of the hearth fires, dash in the pungency of the cutting oils (the oils that they need to assist in cutting the metals and which frequently cause an acne-like eruption of the forearms or the thighs where the oil drips); build nine floors like this and multiply it by three buildings, and you have an idea of a typical plant.

There are people running these machines, men and women from 15 to 70. It's not entirely a young man's job, not altogether an oldster's. It's everybody's! Often it's a girl's job, a girl with her slacks drenched in oil and sweat, her hair tightly netted to prevent its getting caught in the whirling gears, a girl cradling the barrel of a machine gun in her arms or measuring .001 of an inch with a micrometer gauge. Maybe six months ago she was making sixteen dollars a week. Today, she may be earning sixty. Some of the piece workers, the more skillful or the more rapid, get as high as $120. People work eight hours a day, seven days a week, in three shifts. There's little time off. It's a 40-hour week with time-and-one-half to double-time for overtime.

We ate in the workers' cafeterias. There's generally a half hour for lunch. Prices are moderate to low, food good, and quantity man-sized. We had a huge lobster salad in one place for 30c. Living conditions are much worse, however. There's not nearly enough room for everybody. Bathing facilities are very limited. In some places, sleeping accommodations come in 8-hour shifts with three men using the same bed in rotation.

The sulfonamides are helping win the production war. We were in one

plant where they treat 45,000 minor accident cases a month. These workers cut their hands in every conceivable manner, get dirt, grim, oil, foreign bodies jammed into the wounds, yet have almost no infections. Reason —prompt cleansing and dusting of the wound with sulfathiazole powder. The powder is sprayed by an atomizer, must be very fine, and only enough is used. Not so much that it cakes the wound and produces foreign body reaction.

It's a military secret how many guns or planes or tanks they're building. But we'll tell you. There are enough to reach from here to Tokio and back to Berlin with a generous kick to Rome on the side.

—Norman R. Goldsmith, M. D.

What Causes A Person To Be Neurotic?

(Pittsburgh Medical Bulletin)

The question of what causes persons to become neurotic is a very large and complicated one. Psychologists and psychiatrists regard neuroses as escape mechanisms: that is, a refuge from unrecognized fears or intolerable situations. Persons who are afraid of heights, those who have a morbid fear of the water, those who feel suffocated in crowds or close places, or those who can not endure solitude, are all, according to modern conceptions of psychology, suffering from some sort of psychological pressure which becomes intolerable and forces them to seek release unconsciously through a neurosis.

The Expenses of Specialists

(Medical Economics)

Overhead Figures for Fifteen Specialties

Of all full specialists, those practicing anesthesia have the lowest professional expenses; roentgenologists have the highest. To determine the average expenses in your specialty, consult the accompanying tables from Medical Economics' Survey of Medical Practice. The survey covers the year 1939 and is based on reports from 7,707 physicians. Some 1,308 full specialists answered the questions about overhead. Lack of space prevents publication here of the expense figures of partial specialists, but they are available by mail.

Table 2N

Average Annual Professional Expenses of Full Specialists

	Professional Expenses	*Gross Income*
Anesthesia	$1,489	$7,858
Neurology-psychiatry	2,755	7,451
Proctology	2,842	6,933
Pediatrics	2,962	8,018
Obstetrics-gynecology	3,230	9,273
Dermatology	3,366	8,919
Ophthalmology	3,614	11,089
Surgery	3,997	12,161
Urology	4,069	9,299
Internal medicine	4,341	10,655
A.L.R.	4,407	9,879
O.A.L.R	4,816	11,310
Pathology	5,491	10,247
Orthopedics	5,583	10,000
Roentgenology-radiology	5,857	13,534
All full specialists	$4,051	$10,057

Year: 1939.
Sample: 1,308 full specialists.

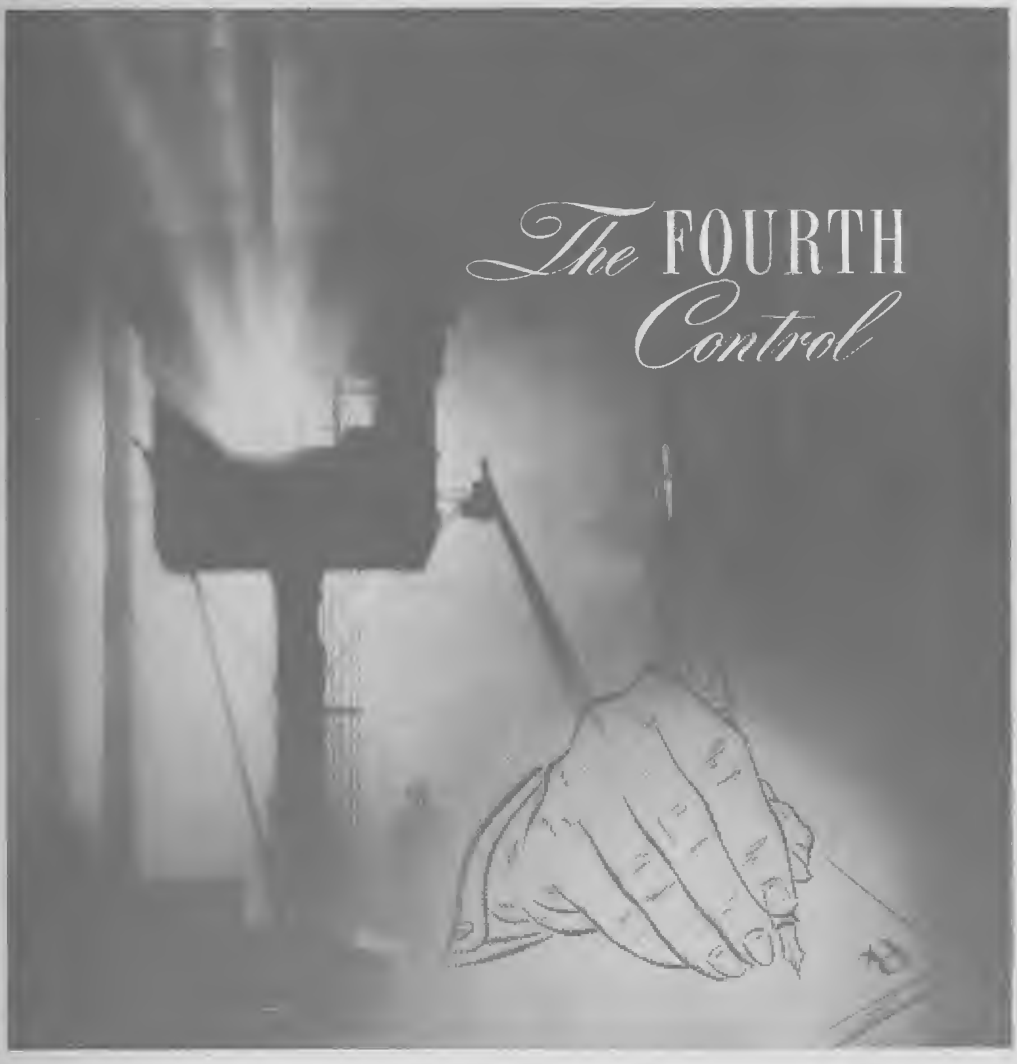
SECRETARY'S REPORT

The regular May Council meeting was held at the office of the Secretary on the 11th of the month.

The regular monthly meeting of the Society was held on the 19th of the month at the Youngstown Club. Dr. Joseph A. Kasper, Director, Bureau of Laboratories Department of Health, Detroit, Michigan, was the speaker. His subject was Acute Infections and in his address he included Aids to Diagnosis and Recent Improvements in Therapy. He also discussed interesting observations in conditions such as diphtheria, erysipelas, meningitis, infectious jaundice, whooping cough and food poisoning.

Members entering military service please notify the Secretary in writing, stating rank, date and new address.

G. M. McKelvey, M. D.,
Secretary.



The major controls in modern medicine are control of infection, control of communicable disease, and control of pain. To these we now add a fourth —the control of fertility. Parents look to their physician for counsel on reliable methods of child-spacing in accordance with physical considerations and other factors which determine the desirability of pregnancy. Ortho-Gynol has been prescribed for years by many thousands of physicians because they have found it effective and well tolerated in continued use.

ortho-gynol

VAGINAL JELLY
ORTHO-CREME • ORTHO DIAPHRAGMS


PABLUM